

Kansas Department on Aging

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N001007 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 10/26/2016 |
| NAME OF PROVIDER OR SUPPLIER ARROWOOD LANE | | STREET ADDRESS, CITY, STATE, ZIP CODE 615 E FRANKLIN HUMBOLDT, KS 66748 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| S 000 | <p>INITIAL COMMENTS</p> <p>The licensure resurvey with investigation of complaint #92226 and #93519 of the above residential health care facility on 10/24/16, 10/25/16, and 10/26/16 resulted in the finding of no deficiency citations.</p> | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE